

# MARYLAND PEDIATRICS REGISTRATION FORM

## PATIENT INFORMATION

First Name	Middle	Last Name	Nickname
Date of Birth	Male	Female	
Home Phone Number	Work Phone number	Cell Phone	
Address	City	State	Zip Code
Emergency contact	Relationship to patient	Phone Number	

## INSURANCE INFORMATION

Primary Insurance Company Name	Policy Number	Group/Plan Number
Insured's Name	Insured's Date of Birth	Relationship to Patient
Secondary Insurance Company Name	Policy Number	Group/Plan Number
Insured's Name	Insured' Date of Birth	Relationship to patient

## PARENTS/GUARDIAN INFORMATION

### Mother's Information

### Father's Information

Name	Name
Mother's SS #                      DOB	Father's SS #                      DOB
Address	Address
<b>E-mail Address</b>	<b>E- mail Address</b>
Home Phone Number      Cell Phone Number	Home Phone Number      Cell Phone Number
Employer Name              Phone Number	Employer Name              Phone Number
Are there any legal restrictions regarding custody? NO or YES If yes, please explain.	

**SIBILINGS INFORMATION**

Name	DOB	Insurance Name : ID Number:
Name	DOB	Insurance Name: ID Number:
Name	DOB	Insurance Name: ID Number:
Name	DOB	Insurance Name: ID Number:

**CMS required**

Language other than English			
Ethnicity	<input type="radio"/> Unknown <input type="radio"/> Hispanic or Latino <input type="radio"/> Not Hispanic or Latino <input type="radio"/> Decline		
Race	<input type="radio"/> American Indian or Alaskan Native <input type="radio"/> Asian <input type="radio"/> African – American or Black <input type="radio"/> Hawaiian Native or Pacific Islander <input type="radio"/> White <input type="radio"/> Decline		
How would you like to be contacted (mark one)	Home Phone,	Cell Phone,	Work Phone,
Medical Issues			
Appointments and other Reminders			
Come Back to Office Recalls			
Billing Status			
General Notice			
Patient Portal	e-mail only e-mail only		

**Privacy and Billing**

I authorize the release of any off my children’s medical information needed to process insurance claims and payments. I have been offered a copy of The Notice of Privacy Practice HIPPA.

I fully understand that I am financially responsible for all charges and balances remaining from claims as well as charges denied or not covered by my insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# MARYLAND PEDIATRICS

## Notice of Privacy Practice

Most of us feel that our health information is private and should be protected. That is why there is a federal law that sets rules for health care providers and health insurance companies about who can look at and receive our health information. This law, called the Health Insurance Portability and Accountability Act of 1996 (HIPAA), gives you rights over your health information, including the right to get a copy of your information, make sure it is correct, and know who has seen it.

### Your Rights

When it comes to your health information, you have certain rights.

### Your Choices

For certain health information, you can tell us your choices about what we share.

### Our Uses and Disclosures

How do we typically use or share your health information?

### Our Responsibilities

We will not use or share your information other than as described here unless you tell us we can in writing.

I understand that patient's health information is private and confidential. I understand that Maryland Pediatrics works very hard to protect patient's privacy and preserve the confidentiality of the patient's personal health information. Maryland Pediatrics Notice of Privacy Practices contains a complete description of my privacy/confidentiality rights. I understand Maryland Pediatrics reserves the rights to change the terms of this Notice of Privacy Practices.

**You can find a complete copy of Maryland Pediatrics Notice of Privacy Practice at [marylandpediatrics.net](http://marylandpediatrics.net) For a hard copy please ask our front desk.**

We participate in the CRISP health information exchange ("HIE") to share your medical records with your other health care providers and for other limited reasons. You have rights to limit how your medical information is shared. We encourage you to read our Notice of Privacy Practices and find more information about CRISP medical record sharing policies at [www.crisphealth.org](http://www.crisphealth.org).

I have been offered and read a full copy of Maryland Pediatrics Notice of Privacy Practice

Patient's Name: \_\_\_\_\_ DOB \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Privacy Officer can be reached at 410 442 4011



## OFFICE POLICY

Letting you know in advance of our office policy allows for a good flow of communication and enables us to better serve you. Please read this carefully. If you have any questions, please do not hesitate to ask a member of our staff.

### **Calling for Appointments:**

We offer same day sick appointment for our patients

Well checkups or Physical exams, Sport Physicals, Med – checks; please call ahead of time to make any of these appointments, this will assure you, time and day most convenient for you.

### **Cancelling Appointments:**

If you must cancel your appointment, please call 24 hours or more prior to your appointment so we can open our schedule to assist other patients. There is a fee for cancelling appoints less than 24 hours prior to your appointment.

### **Not Showing to your Appointment:**

Missing an appointment prevents us from seeing other patients in need of our service. It is our office policy to charge a fee for no show. After 3 no shows our office may contact you to let you know you need to transfer to another practice.

### **After Office Hours:**

If you have an emergency please call 911.

There is always a doctor on call. Call our office main number 410 442-4011, the answering service will put you in contact with the doctor on call.

### **Health Insurance:**

We accept most private and state health insurance.

We submit all medical claims on your behalf to your insurance plans.

According to your insurance plan, you are responsible for any and all co-payments, deductibles, and services not covered by your insurance. Co-payments are due at time of service. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.

A fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

**IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INACTIVE OR INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT.**

If we are your primary care physician, make sure our name and/or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.

**YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.**

If you have no insurance, payment for an office visit is to be paid at the time of the visit.

If our providers do not participate in your insurance plan, payment in full is expected from you at the time of your office visit.

**Transferring Medical Records:**

We charge a state regulated fee per child to copy or transfer medical records.

**Forms:**

If your child has school, camp, or sport forms to be completed, there is a **fee** charge per form. Payment is due when the forms are dropped off. We have a 5- to 7-day turnaround time for forms. If a form is needed sooner, you may request *rush* service for an additional fee.

**Prescription Refills:**

For monthly medication refills, we require 48 hours' notice, please plan accordingly. All prescriptions are sent electronically to the pharmacy of your choice.

For controlled substances prescriptions; parents must pick up prescriptions at our office and your child must have a med-check exam within the last 4 months in some cases 3 months depending on medication side effects.

**Referrals:**

We require that referrals be requested at least 3 days prior to your specialist appointment. Referrals need to be approved by our doctor. When calling our office, please have ready doctor's name and phone number as well as appointment day and time.

I have read and understand this office policies and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) \_\_\_\_\_

\_\_\_\_\_  
Responsible party member's name                      Relationship

\_\_\_\_\_  
Responsible party member's signature                      Date